MISSED OPPORTUNITIES FOR MODERN FAMILY PLANNING SERVICES AMONG
WOMEN ATTENDING CHILD HEALTH CLINICS IN IGANGA/MAYUGE
DEMOGRAPHIC SURVEILLANCE SITE

BY

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DECLARATION
I, Gertrude Namazzi, do hereby declare that this research report entitled ‘Missed Opportunities for Modern Family Planning Services Among Women Attending Child Health Clinics in Iganga/Mayuge DSS’ has been prepared and submitted in fulfillment of the requirements of the MakSPH-CDC Fellowship Program and has not been submitted for any academic qualifications.

Signed ………………………………………….. Date……………………………

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Signed………………………………………….. Date……………………………

Dr. Peter Waiswa,

Host Institution Mentor

Signed…………………………………………. Date…………………………..

Dr. Florence Baingana

Academic Mentor
DEDICATION

I dedicate this work to my late uncle, Francis Kayondo, who lived a selfless life and took care of me like his own. He gave me the most precious gift in this world; that is education. I will always be indebted to him. May his soul rest in eternal peace.
ACKNOWLEDGEMENT

My appreciation goes to my host and academic mentors for their support in writing this report and the entire period of the Fellowship. I am also grateful to Dr Elizabeth Ekirapa, Edward Galiwango, and the entire staff of Iganga/Mayuge DSS for the assistance in various ways that has enabled me to complete this Fellowship programme successfully. I further extend my thanks to the data collectors and all the respondents who participated in this study. I am also grateful to the MakSPH-CDC programme staff and fellow Fellows for their support.
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<tr>
<td><strong>ANC:</strong> Ante Natal Care</td>
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<tr>
<td><strong>CPR:</strong> Contraceptive Prevalence Rate</td>
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<td><strong>DHT:</strong> District Health Team</td>
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<td><strong>DSS:</strong> Demographic Surveillance Site</td>
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<td><strong>FP:</strong> Family Planning</td>
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<td><strong>HC:</strong> Health Center</td>
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<td><strong>HMIS:</strong> Health Management Information System</td>
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<td><strong>HSD:</strong> Health Sub District</td>
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<td><strong>HSSP:</strong> Health Sector Strategic Plan</td>
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<td><strong>INDEPTH:</strong> International Network for continuous Demographic Evaluation of Populations and their Health</td>
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<tr>
<td><strong>IUD:</strong> Intra-Uterine Device</td>
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<td><strong>MANEST:</strong> Maternal Newborn Study</td>
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<td><strong>MMR:</strong> Maternal Mortality Ratio</td>
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<td><strong>NCST:</strong> National Council of Science and Technology</td>
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<tr>
<td><strong>PNC:</strong> Post Natal Care</td>
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<td><strong>TFR:</strong> Total Fertility Rate</td>
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<td><strong>UDHS:</strong> Uganda Demographic Health Survey</td>
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<td><strong>UNEST:</strong> Uganda Newborn Study</td>
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<td><strong>UNFPA:</strong> United Nations Population Fund</td>
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<td><strong>WHO:</strong> World Health Organization</td>
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OPERATIONAL DEFINITION

Unmet need for family planning: The percentage of women in reproductive age group who are fecund and sexually active but are not using any method of contraception, and report not wanting any more children or wanting to delay the birth of their next child (WHO 2011).

Missed opportunities: Occasions on which mothers in the reproductive age group seek health care and are in contact with a health provider but lose the chance of receiving family planning services (inclusive of counseling and provision of methods)
ABSTRACT

Introduction

Pregnancies which are too many, too early and too often result in maternal/child morbidity and mortality. Delivery of effective family planning services has a direct impact on maternal/child wellbeing. While access to health units was good and sensitization of communities was carried out, the contraceptive prevalence rate remained low in Iganga District, like in many parts of the country. This study was therefore conducted to assess client and health facility factors that contribute to missed opportunities for modern family planning service use among women attending child health clinics in Iganga/Mayuge Demographic Surveillance Site in order to inform policy and design of interventions that can improve uptake.

Methods

A facility-based cross sectional study was conducted in Iganga/Mayuge DSS using quantitative and qualitative methods of data collection. A questionnaire was used for exit interviews among 371 mothers attending child health clinics in six health facilities. The mothers were interviewed on their exposure to family planning information, counseling during pregnancy, childbirth and postnatal period, and their socio-economic backgrounds. The semi structured interviews were carried out among two district health team members and six health providers in charge of child health clinics and family planning services. In addition, two men attending child health clinics were interviewed.

Quantitative data were analyzed using EpiData version 3.1. Chi square, odds ratios, 95% confidence intervals and p-value set at 0.05 were used to determine the statistical significance of the associations between independent variables and family planning uptake since birth of the last baby. Qualitative data were transcribed, coded and analyzed using content thematic analysis.
Results

Uptake of family planning (FP) by mothers attending child health clinics was only 27% for all methods. However, majority of mothers (71.7%) were interested in using family planning methods in future. The low uptake mainly resulted from low rate of counseling of mothers on FP services. Only 23.2% of the mothers were counseled at time of discharge after delivery and less than a third (24.5%) were counseled in child health clinics. These forms of exposure to FP information were associated with improved FP uptake [from 23.2% to 38.5% (p=0.004), and 22.8% to 40.7% (p=0.001)] respectively. Access to FP information posters did not improve FP uptake (p=0.5) due to the limited information they carried. Although modern methods were available in most of the facilities, health workers had limited skills for effective FP service provision. The fear of side effects of modern methods, and failure to discuss FP issues with spouses aggravated the missed opportunities to FP uptake among clients.

Conclusion

The low rate of counseling during Child health clinics and immediately after delivery, and the limited skills of service providers lead to missed opportunities for FP uptake. Integration of FP in Maternal and Child health services, and enhancement of health workers’ competences is critical for effective service delivery and improved uptake.
1.0 INTRODUCTION AND BACKGROUND

Access to family planning services and contraception is critical with the world population currently at seven billion inhabitants. Unfortunately, too many people (250 million) don't have the means to control their fertility (UNFPA 2011). The health of women is closely related to their reproductive role. Pregnancies which are either too early, too close, too many or too late, expose mothers to high morbidity and mortality during pregnancy and childbirth (Gebremedhin 2002). Child survival is also influenced by mother's parity, birth interval, and birth order in addition to duration of breastfeeding (Sebastian MP 2010), (WHO 2011). Among adolescents and young adults, the major health problems include, among others, complications related to abortions and childbirth. Delivery of effective family planning (FP) services is therefore fundamental and cost effective in ensuring a healthy and productive population.

Family planning services are defined as educational, comprehensive medical or social activities which enable individuals, including minors to determine freely the number and spacing and timing of their children, and to select the means by which this may be achieved (WHO 2011). Such means include use of contraceptives and the treatment of involuntary infertility. Modern contraceptive methods include all hormonal methods (i.e., the pill, injectables and implants), IUDs, male and female sterilization, condoms and modern vaginal methods (e.g., the diaphragm and spermicides) (Asma Balala 2009)

A woman’s ability to space and limit her pregnancies has a direct impact on her health and well-being as well as on the outcome of each pregnancy (WHO 2011). Based on the findings of Adding It Up, a joint Guttmacher/UNFPA report (2009), they argued that doubling that modest investment in FP and maternal child health programmes would result in a 70% reduction in maternal deaths and a 44% reduction in the deaths of newborns with additional health, societal and economic benefits (Susheela Singh 2009). They further posit that providing women with family planning information and services frees up scarce resources that could be used to provide universal access to maternal and
newborn care. In addition, 50% of all maternal mortality in the developing world could be addressed through FP services (Winikoff B 1987).

Sub-Saharan Africa has an average TFR of 5.1, the highest average in the world; which is twice that of South Asia (2.8) (WorldBank 2009). The average CPR of 22% is half of South Asia (53%) due to low acceptance and high cultural resistance to FP. Consequently, the maternal mortality ratio of 500/100,000 live births is high and most SSA countries are not on track to achieve MDG5 (WHO 2012).

In Uganda, the maternal mortality ratio (MMR) has barely reduced in the past decade; currently at 438/100,000 live birth (UDHS 2011). The total fertility rate (TFR) of 6.2 has resulted in a population growth rate of 3.2%, the fastest in Africa and the third highest in the world. The contraceptive prevalence rate (CPR) among married women, which has recently improved from 24% to 30% (UDHS 2011), is still unfortunately low. Uganda also has a high unmet need for FP services of 41% (UDHS 2006), (Shane Khan 2008).

1.1 Health sector organization and service delivery

According to the Health Sector Strategic Plan (HSSP) III, and the National Policy Guidelines and Standards for Sexual and Reproductive Health and Rights (2006), all levels of formal health care should offer an appropriate range of family planning services (Table 1) (MOH 2000). General hospitals provide preventive, promotional, curative maternity, in-patient health services, surgery, blood transfusion, laboratory and medical imaging services. Below hospitals are HC IVs which serve as the Health Sub District (HSD) headquarters. The HSD is mandated with planning, organization, budgeting and management of the health services at this and lower health center levels. The HC IV serves the county catchment area; offers specialized reproductive services and curative, preventive, promotional and rehabilitative services in the health sub district.

HC IIIs provide basic preventive, promotional, curative care and provide support supervision of the community and HC II under their jurisdiction. There are provisions for
laboratory services for diagnosis, maternity care and first referral cover for the sub-county. The HC IIs, run by an enrolled comprehensive nurse, provide the first level of interaction between the formal health sector and the communities. HC IIs only provide outpatient care and community outreach services including child health immunization clinics.

Table 1: Level of care vs Family Planning services

<table>
<thead>
<tr>
<th>Level of care</th>
<th>FP services</th>
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<tbody>
<tr>
<td>Hospital</td>
<td>Counseling, Oral contraceptives, Barrier methods, Injectable Contraceptives, Implant, IUDs, Vasectomy and Bilateral tubal ligation</td>
</tr>
<tr>
<td>Health Centre IV</td>
<td>Counseling, Oral contraceptives, Barrier methods, Injectable Contraceptives, Implant, IUDs,</td>
</tr>
<tr>
<td>HC III</td>
<td>Counseling, Oral contraceptives, Barrier methods, Injectable contraceptives, Implant,</td>
</tr>
<tr>
<td>HC II</td>
<td>Counseling, Oral contraceptives, Barrier methods, Injectable Contraceptives</td>
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2.0 LITERATURE REVIEW

A number of factors are responsible for the low CPR in the country; both health service factors and community factors have been recognized as barriers to uptake of family planning services.

2.1 Health service factors

A major goal of family planning programmes is to help couples achieve their reproductive intentions. To assist clients to achieve these goals family planning services should be tailored to meet clients’ needs. Effective delivery and uptake of modern family planning methods depends a lot on the competency and attitudes of the providers particularly for the long acting and permanent methods. According to Kasedde S, (2000) some of the constraints observed in family planning delivery include lack of trained staff or transfer of trained and motivated staff resulting in decrease of commitment of the remaining staff. In addition, there is poor information provision ranging from poor display of education and communication materials, to limited disclosure of methods and counseling about modern FP methods especially the long term and permanent ones (Kasedde 2000). Also documented are the negative attitudes of service providers, poor accessibility to services, and inadequate family planning supplies at the health facilities (Mbonye 2003). Other service factors that may also hinder FP service utilization include: long waiting times, unofficial fees in the public sector, and limited quantity of information provided during care (Jitta 2008).

Family planning services can be made more accessible and convenient to clients if they take into account other service needs of the potential clients. Integration of FP services for female clients with frequently used Maternal and Child Health (MCH) and reproductive services would lower costs to clients and reduce missed opportunities for service delivery (Katherine W 2010). A study conducted in Kumi District, Uganda found out that only about 18% of mothers attending ANC clinics received messages regarding family planning services and yet 71% intended to use FP in the future (Mbonye 2003).
Figure 1 below highlights the various reproductive services in which FP services can be integrated.

![Integration of Family Planning services into reproductive services](image)

**Figure 1: Integration of Family Planning services into reproductive services**
*(Katherine W 2010)*

2.2 **Community/client related factors**

*Knowledge, attitudes and perceptions towards family planning*

Individual knowledge about contraceptive methods is closely linked to the use of the methods (Mbonye 2003); (Agyei 1995). Knowledge of family planning methods was found to be universal in Uganda, with over 90% of women in the reproductive age group having heard of at least 1 method of contraceptives (UDHS 2006) (Nattabi B 2011). The attitudes towards contraceptive use were favorable. However, the level of contraceptive use was found low in comparison with knowledge and attitudes. There is thus a need to assess the barriers to higher contraceptive uptake in Uganda, since knowledge of family planning methods is very high.
Demographic and Socioeconomic factors

According to studies conducted in Uganda, post-primary education and urban residence were strong predictors of knowledge and favourable attitudes towards FP services. The presence of the spouse in the household and discussion of family planning with spouse were also found to strongly influence contraceptive use. However, child mortality did not have any impact on uptake of FP services (Nattabi B 2011) (Agyei 1995).

The wealthy were found to have more knowledge about FP methods and with a higher Contraceptive Prevalence Rate (CPR) compared to the poorest; consequently the richest had a Total Fertility Rate (TFR) of 4.3 far less compared to the poorest of 8.0 (Agyei 1995), (UDHS 2006).

Practices

Contraceptive prevalence rate among married women by any method has barely improved from 19% in 1995, 24.4% in 2006, to 30% in 2011. The use of modern methods has slowed somewhat, while use of traditional methods declined between 1995 and 2000. Injectable contraceptives are the commonly used method among married women because they are long lasting, convenient to them, and can be used without the knowledge of the male partners who may not agree to family planning use (MoH 2000b). The contraceptive mix changes with the sexually active unmarried women; with condom use being the highest at 27% followed with injectables at 13% (Shane Khan 2008)

2.3 Community based family planning interventions

Community-based distribution (CBD) of family planning provides a way of reaching the rural underserved populations in developing countries. Studies have documented that community based health workers can safely provide injectable contraceptives and subsequently increase contraceptive coverage (Brunie A 2007), (Ndola Prata 2011). In Uganda more than 80 percent of the population lives in rural areas where many women do not have adequate access to health facility family planning services. Although 82% of the 80 districts in the country in 2007 had had a CBD program at one time only 32% of
the districts were found with active, financially supported programs (FHI 2007). Consequently, many women would still depend on facility based family planning services.

2.4 Policy environment

An effective policymaking and implementation process is the foundation of scalable and sustainable health programs including those that integrate FP.

The Uganda Population Policy (2008) recognizes the intricate and fundamental interrelationships between population and development. The policy further recognizes that the process of development has an important effect on population trends and that population factors, in turn, have a major impact on the attainment of development objectives and targets (Pop-Secretariate 2008).

The objectives of the National Population Policy (1995, 2008) include among others; to promote and expand a comprehensive family planning delivery system, to reduce the unmet need for family planning and to educate individuals and couples to appreciate the relationship between family size, health and welfare of the family. The Policy recognizes, among others, that the country will develop faster if we attain a population growth rate that matches with economic growth and development. To achieve the balance between the population growth rate and economic development, efforts must be made to lower morbidity and mortality; reduce incidence of high risk births; and attain a family size that will enhance the health and welfare of the family. There is a national drive to strengthen family planning services in order to have a substantial decline in fertility. Efforts in Uganda have concentrated on training health workers and ensuring availability of contraceptive supplies at service delivery points, and the policy advocates for an integrated package of services to clients however, there is limited information regarding implementation barriers that result in missed opportunity.
3.0 PROBLEM STATEMENT

Family planning is fundamental in the effort to reduce the Total Fertility Rate and the consequential maternal mortality and morbidity as well as contributing to improvement in infant welfare.

FP uptake in Iganga District like in many other districts in Uganda is very low and the factors responsible for this are not clear. According to Health Management Information System reports of the year 2010, the CPR was only 26.8% (HMIS 2010). Many mothers (70%) bring their infants for immunization (DPT1), unfortunately the coverage of FP or its uptake in these clinics is still low; a supposition of missed opportunities. This has vast consequences like the high TFR in Iganga District of 7.5 children per woman which undermines the health of the mother and creates unfavorable conditions for the infant and child survival.

The Health Directorate has opened more health units to improve on access of health services; more than 70% of the population is within 5 km distance from health unit. All levels of health facility should be able to provide family planning services. Sensitization of the community on use and importance of family planning has been ongoing for the last two years by community health workers under the Uganda Newborn Study (UNEST). However, the extent of FP service provision or missed opportunities is not clear.

3.2 Justification

The UNEST and District Health Team (DHT) noted with concern the inappropriately very low utilization of family planning services compared with the number of mothers that bring back their infants for immunization and they are wondering why mothers do not receive family planning services during the child health clinics! These clinics offer opportunities to service providers to bridge the gap between them and the potential clients for family planning services, however, the coverage of FP or its uptake in these clinics remains low.
Family planning services are an important component to antenatal care (ANC) and postnatal care (PNC) services as a strategy to reduce the high maternal mortality ratio (348/100,000 live births), maternal morbidity and infant mortality in the district through the reduction of the TFR; the less number of pregnancies and the more space in between pregnancies the less the risk to die because of pregnancy related complications.

Under the maternal newborn care study (MANEST), we plan to strengthen health facilities in order to improve maternal and infant health care. The results of this study about the factors (facility and client factors) contributing to missed opportunities among women attending child health clinics will appropriately inform the final design of the intervention that will improve uptake of FP methods in the DSS and the district at large.
4.0 Conceptual framework for missed opportunity for modern family planning services among women attending child health clinics in Iganga/Mayuge Demographic Surveillance Site

**Missed opportunities for FP services**

**Client related factors**
- Age
- Marital status
- Lack of Education
- Low income
- Lack of transport costs
- Lack of knowledge of FP services
- Negative attitudes, beliefs and practices
- Perceived need for many children/social security
- Fear of side effects of modern methods
- Lack of awareness of benefits

**Health service factors**
- Long waiting time
- Lack of effective communication
- Excessive work load
- Inadequate staff
- Service organization
- Long distance to Health facilities
- Limited support supervision
- Limited funds for service delivery
- Stock outs of contraceptives
- Inadequate motivation of health workers

**Community and House Hold factors**
- Gender issues
- Limited partner support & male involvement
- Decision making
- Lack of women empowerment

**Low uptake of FP in child health clinics**
- High TFR
- High Maternal morbidity/mortality
- High Infant Mortality

Figure 2: Conceptual framework for missed opportunities for Family Planning services
Narrative for the conceptual framework

Health service factors such as stock outs of FP supplies, and inadequate number of health care workers in the health facilities lead to lack of effective communication to the mothers during the child health clinics and following deliveries. Consequently, mothers have limited awareness of FP services and thus low demand for such services. This may also be a consequence of excessive workload and limited motivation resulting into provision of less quality services hence missed opportunities.

The socioeconomic factors that may affect the demand for FP services include poverty/low income of mothers and their spouses which results in lack of transport fare and money for other costs. Lack of education of mothers also limit their awareness of the importance, and hence the low uptake of the FP services. The fear of side effects and the perceived need of many children as social security further hinder the uptake of FP methods. Lack of male involvement and limited decision making by mothers in the household as well as lack of empowerment in resource control limit their capacity to utilize health services including FP, hence the low demand.
5.0 OBJECTIVES

5.1 General Objective
To assess client and health facility factors that contribute to missed opportunities for modern family planning services among women attending child health clinics in Iganga/Mayuge DSS in order to inform policy and design of interventions that can improve uptake of FP services

5.2 Specific Objectives
1. Explore the health facility barriers that contribute to missed opportunities for family planning services in Iganga/Mayuge DSS,
2. Establish the clients’ knowledge, attitude, and utilization barriers for family planning methods in the DSS,
3. Determine the proportion of women attending child health clinics that were exposed to information about family planning since the last birth,
4. Determine the percentage of women that are currently using modern family planning methods
5. Determine the unmet need for family planning among women attending child health clinics in Iganga/Mayuge DSS
6.0 METHODS

6.1 Description of the Study Setting

The study was conducted from the health facilities of the Makerere University-operated Iganga/Mayuge Demographic Surveillance Site (DSS) which is mainly found in Iganga District and partly in the neighboring Mayuge District.

Iganga District is located in the Eastern region of Uganda, about 120 km east of the capital Kampala, and has an estimated population of 466,200 people; most (over 90%) of this population is rural. The district has 1 hospital, 23 health centers with in-patient care and 52 facilities which only provide outpatient care. However, health infrastructure, staffing and services remain inadequate as was shown in a district wide quality audit using the Yellow Star approach (MOH, 2006)

The DSS is a full member of the International Network for continuous Demographic Evaluation of Populations and their Health (INDEPTH). The DSS has a population of about 67,200 people in 65 villages, 18 parishes and 12,000 households. The site has 1 hospital, 1 HC IV, 4 HC IIIIs and 12 HC IIs (DSS 2010).

6.2 Study Design: Cross sectional survey which was health facility based

6.3 Study Population: Mothers that delivered within one year prior to the study and were attending child health clinics, and health facility in-charges and midwives

6.4 Sample size determination:

To estimate the true proportion of women with unmet need for family planning services within ± 5 % points with

95% confidence, with \( p = 0.41 \) (UDHS 2006) \( (q=1-p) \), \( d=0.05 \), \( \alpha =0.05 \) and \( Z=1.96 \);

Given that:

\[
n = \frac{Z^2 \cdot pq \text{ (Leslie Kish 1965)}}{n} = (1.96 \times 1.96) \times (0.41 \times 0.59) = 371
\]
thus the sample size was 371 mothers

\[ p = \text{Prevalence (unmet need for family planning)} = 41\% \ (\text{UDHS 2006}) \]

\[ q = 100\% - 41\% = 59\% \]

\[ d = \text{maximum error the PI was willing to allow, between the estimated prevalence of the outcome P and the true prevalence in the population} = 5\% \]

For the qualitative study, 2 health workers (in-charge and one midwife) per health facility level (Levels II, III, IV, Hospital) were interviewed; giving a total of 12 interviews

6.5 Sampling procedure: The study was conducted in 6 out of 18 health facilities. These included the hospital, health centre IV, 2 HC IIIIs and 2 HC IIs. Health center IIIIs and HC IIs were selected by simple random sampling method. The sample per health facility was then allocated proportionate to the level of care. Child health clinic exit face to face interviews with mothers who had brought their infants on the day of interview were conducted for the quantitative study. The mothers who were interviewed were selected consecutively following consultations with a health provider on each day of the child health clinic until the sample was attained. The data collection period was spread out for a period of one month to enable us capture any variations. For qualitative study, purposively selected midwives who run child health clinics were interviewed. The District Health Officer and district nursing officer of Iganga District were also interviewed. In addition, two men who had brought their infants to the child health clinics were also engaged in In-depth interviews.

6.6 Data collection: Quantitative and qualitative methods of data collection were employed. A check list was used to establish staffing levels, the availability of contraceptives and other supplies required in provision of modern contraceptives (Annex 3). A structured questionnaire was employed for exit interviews of 371 mothers. The mothers were interviewed on their exposure to family planning information, counseling during pregnancy, childbirth and postnatal period, and their socio-economic backgrounds
A semi-structured interview guide was used for key informant interviews with health providers and district officials. The interviews covered areas of training in FP services, availability of FP methods, and challenges faced in provision of such services (Annex 2).

6.7 Study Variables

6.7.1 Dependent Variables

- Current use of modern family planning methods

6.7.2 Independent Variables

Client related factors

- Socio-demographic characteristics (e.g. Age, Education level of mother and spouse, marital status, religion)
- Economic status: Employment of mother and spouse, monthly income, or household assets
- Awareness (knowledge of at least two methods) of modern family planning methods
- Source of information concerning family planning
- Attitude and perception towards family planning services
- Fear of side effects
- Parity of the mother
- Sex of her children
- Decision making in a home
- Partner support
- Monogamous or polygamous relationship

Health service factors

- Staffing of health facilities
- Access to IEC materials for family planning in child health clinics
- Availability of modern family planning methods
• Support supervision
• Work overload for health providers
• Attitudes of health workers
• Motivation of health workers

7.1 Data management and analysis and Quality assurance

7.1.1 Quality assurance
All data collection tools were translated into Lusoga, the local language. Field assistants were trained by the principal investigator in the administration of the tools. Tools were pre-tested prior to data collection. The PI supervised the data collection exercise. Daily data editing to ensure consistence and completion was done.

7.1.2 Data management and analysis
Quantitative data were analyzed using Epidata version 3.1 and then presented as frequency tables and cross-tabulations. Chi square, odds ratios, 95% confidence intervals and p-value set at 0.05 have been used to determine the statistical significance of the associations between independent variables and FP uptake.

Qualitative data were analyzed using content thematic analysis. Interviews were transcribed in English, in order to be used for identifying individual bits of data. The transcripts were read and re-read in full so as to annotate any thoughts in the margin. This involved examining the text closely, line by line, to facilitate a micro analysis of the data. Coding was then carried out. Items relating to similar topics were organized into categories to enable identify emerging themes. The proto-themes were examined to start definitions.

7.2 Ethical considerations
Permission to conduct the study was obtained from the Institutional Review Board of Makerere University School of Public (MakSPH) and the Uganda National Council of Science and Technology (UNCST). Authorization to conduct the study was also received
from the District Health Officer (DHO) as well as the In-charges of health facilities where the study was conducted. Informed consent was sought from each respondent (the consent forms are attached as Annex 5 and 6); privacy and confidentiality were safeguarded throughout the course of the study.

7.3 Study limitations:

The study being health facility based could have been subjected to selection bias. However, we spread out data collection to a month’s period in order to capture any variations
8.0 RESULTS

Information was obtained from interviews of 371 mothers from six health facilities; and we had 100% response rate. About a third (32.9%) of the respondents (122) were from Iganga hospital, 17.5% from HCIV, 33.4% from two HC IIIs and 16.2% from two HC IIs. Qualitative data were from 12 health workers, 2 district health officers and 2 men.

The results revealed that most (67.9%) of the respondents were young in the age group of 20 to 30 years with the mean age of 25.3 years (SD=8.2). A few (17%) were more than 30 years (Table 1). Ninety percent of the mothers were married and about 30% were living in a polygamous state.

8.1 Family Planning uptake

About a third, 27% (100) of the respondents were using some form of family planning method. Majority (71.7%, n=271) of those who were not on FP method expressed desire to use FP in the future. Of those on contraception, most women, 84%, were using modern FP methods compared to 15% on traditional methods. Most commonly used method was injectable contraceptives (37%) followed with condoms (24%) (Fig 3). Half (50%) of the respondents on FP method started using it within two months after birth.

The main source of the FP method was health facility (49%), followed with private clinics and drug shops (Fig 4)
Figure 3: Distribution of Family Planning methods used

Source of Family Planning method

- Health facility: 49%
- Private clinic: 17%
- Drug shop: 17%
- General shop: 13%
- Other sources: 4%

Figure 4: Sources of Family Planning methods
8.2 Background characteristics of the respondents vs family planning uptake

The study findings revealed that social demographic characteristics of the mother like age, marital status, and level of education do not affect the likelihood of FP uptake (Table 2). Similarly, although almost half of the respondents were Muslim, the uptake of FP methods was not statistically different from that of the non Muslims.

Table 2: Social characteristics of the respondents vs Family Planning uptake

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>FP uptake</th>
<th>No FP uptake</th>
<th>Total</th>
<th>X²</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age of the mother</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;20</td>
<td>16(28.6)</td>
<td>40(71.4)</td>
<td>56(15.1)</td>
<td>0.878</td>
<td>0.645</td>
</tr>
<tr>
<td>20-30</td>
<td>70(27.8)</td>
<td>182(72.2)</td>
<td>252(67.9)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&gt;30</td>
<td>14(18.7)</td>
<td>49(81.3)</td>
<td>63(17)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Marital status</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>92(27.5)</td>
<td>242(72.5)</td>
<td>334(90)</td>
<td>0.598</td>
<td>0.441</td>
</tr>
<tr>
<td>Divorced/Separated/Single</td>
<td>8(21.6)</td>
<td>29(78.4)</td>
<td>37(10)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Polygamous status</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>23(21.1)</td>
<td>86(78.9)</td>
<td>109(29.4)</td>
<td>2.688</td>
<td>0.261</td>
</tr>
<tr>
<td>No</td>
<td>66(29.3)</td>
<td>159(70.7)</td>
<td>225(60.6)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do not know</td>
<td>11(29.7)</td>
<td>26(70.2)</td>
<td>37(10)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Age of baby in months</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;6</td>
<td>55(22.6)</td>
<td>188(77.4)</td>
<td>243(65.5)</td>
<td>6.677</td>
<td>0.010</td>
</tr>
<tr>
<td>6-12</td>
<td>45(35.2)</td>
<td>83(64.8)</td>
<td>128(34.5)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Number of children alive</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>35(28.0)</td>
<td>90(72.0)</td>
<td>125(33.7)</td>
<td>1.392</td>
<td>0.499</td>
</tr>
<tr>
<td>2-4</td>
<td>54(28.1)</td>
<td>138(71.9)</td>
<td>192(51.8)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&gt;4</td>
<td>11(20.4)</td>
<td>43(79.6)</td>
<td>54(14.5)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Religion</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Christian</td>
<td>56(28.6)</td>
<td>140(71.4)</td>
<td>196(52.8)</td>
<td>0.552</td>
<td>0.458</td>
</tr>
<tr>
<td>Moslem</td>
<td>44(25.1)</td>
<td>131(74.9)</td>
<td>175(47.2)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Level of education of mother</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>3(18.8)</td>
<td>13(81.2)</td>
<td>16(4.3)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary</td>
<td>36(22.2)</td>
<td>126(77.8)</td>
<td>162(43.7)</td>
<td>3.638</td>
<td>0.162</td>
</tr>
<tr>
<td>O’level</td>
<td>45(31.9)</td>
<td>96(68.1)</td>
<td>141(38.0)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A’level and higher</td>
<td>19(27.9)</td>
<td>49(72.1)</td>
<td>68(18.3)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Occupation of mother</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Salaried worker</td>
<td>14(40)</td>
<td>21(60)</td>
<td>35(9.4)</td>
<td>3.968</td>
<td>0.554</td>
</tr>
<tr>
<td>Business</td>
<td>22(28.6)</td>
<td>55(71.4)</td>
<td>77(20.8)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Laborer</td>
<td>2(22.2)</td>
<td>7(77.8)</td>
<td>9(2.4)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Peasant farmer</td>
<td>32(25.0)</td>
<td>96(75.9)</td>
<td>128(34.5)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>House wife</td>
<td>26(25.2)</td>
<td>77(74.8)</td>
<td>103(27.8)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>4(21.1)</td>
<td>15(78.9)</td>
<td>19(5.1)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The findings from Table 2 revealed that about 32% of the mothers who reached secondary education used FP methods compared to 22% of those who had only primary
education, however, the difference was not statistically significant (P=0.16). Salaried respondents were more likely to use FP methods (40%) compared to those in business (28.6%), housewives (25%) and peasant farmers (25%), but these differences in uptake of FP methods were not statistically different (P= 0.55).

### 8.3 Knowledge of family planning

This study revealed that knowledge of FP methods was almost universal; with 96.2% mentioning at least one method. The most known method was injectable contraceptive (85.2%), followed with oral pills, IUD, and male condoms (Table 3). Knowledge of more than three methods of FP improved the chances FP uptake from 25.6% to 30.1% (P-value=0.02) (Table.4).

**Table 3: Knowledge of Family Planning methods**

<table>
<thead>
<tr>
<th>Contraceptive</th>
<th>Number of mothers n</th>
<th>Percentage %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Injectable</td>
<td>316</td>
<td>85.2</td>
</tr>
<tr>
<td>Pills (Oral contraceptives)</td>
<td>281</td>
<td>75.7</td>
</tr>
<tr>
<td>IUD</td>
<td>242</td>
<td>65.2</td>
</tr>
<tr>
<td>Male condoms</td>
<td>169</td>
<td>45.6</td>
</tr>
<tr>
<td>Implants</td>
<td>105</td>
<td>28.3</td>
</tr>
<tr>
<td>Female condoms</td>
<td>60</td>
<td>16.2</td>
</tr>
<tr>
<td>Female sterilization</td>
<td>48</td>
<td>13.0</td>
</tr>
<tr>
<td>Rhythm method</td>
<td>39</td>
<td>10.5</td>
</tr>
<tr>
<td>Withdraw</td>
<td>39</td>
<td>10.5</td>
</tr>
<tr>
<td>Emergency contraceptives</td>
<td>23</td>
<td>6.2</td>
</tr>
<tr>
<td>Male sterilization</td>
<td>15</td>
<td>4.0</td>
</tr>
<tr>
<td>Lactation amenorrhea</td>
<td>15</td>
<td>4.0</td>
</tr>
<tr>
<td>Spermicides</td>
<td>1</td>
<td>0.3</td>
</tr>
</tbody>
</table>

### 8.4 Barriers to Family Planning Uptake

During the interviews several reasons were given by the respondents for failure to use FP methods; these barriers were mainly: the mother not having seen her menstruation periods yet (baby being still young) (52.4%; n=271), and fear of side effects of the contraceptives (23.6%) (Fig 5).
8.5 Exposure to information about family planning

This study revealed that most mothers (65.2%) were counseled in FP during ANC clinics; however, this counseling did not improve the likelihood of a mother to use FP methods after delivery (27.3% vs 26.4% p value= 0.85) (Table 4). On the other hand, counseling after delivery and in child health clinic was low at only 23.2% and 24.5%. These forms of FP information exposure were found to increase the chances of FP uptake; from 22.8% to 40.7% immediately after delivery, (P=0.001) and from 23.2% to 38.5% during child health clinics (P=0.004)
Table 4: Proportion of women exposed to information since the last birth vs Family Planning uptake

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>FP Uptake n/</th>
<th>FP non Uptake n/</th>
<th>Total n/</th>
<th>OR</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>%</td>
<td>%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Counseling during ANC</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>66(27.3)</td>
<td>176(72.7)</td>
<td>242(65.2)</td>
<td>0.036</td>
<td>0.850</td>
</tr>
<tr>
<td>No</td>
<td>34(26.4)</td>
<td>95(73.6)</td>
<td>129(34.8)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Counseling by delivery attendant</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>35(40.7)</td>
<td>51(59.3)</td>
<td>86(23.2)</td>
<td>10.740</td>
<td>0.001</td>
</tr>
<tr>
<td>No</td>
<td>65(22.8)</td>
<td>220(77.2)</td>
<td>285(76.8)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Counseling in child health clinic</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>35(38.5)</td>
<td>56(61.5)</td>
<td>91(24.5)</td>
<td>8.109</td>
<td>0.004</td>
</tr>
<tr>
<td>No</td>
<td>65(23.2)</td>
<td>215(76.8)</td>
<td>280(75.5)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Access to FP information posters</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>74(27.8)</td>
<td>192(72.2)</td>
<td>266(71.7)</td>
<td>0.357</td>
<td>0.550</td>
</tr>
<tr>
<td>No</td>
<td>26(24.8)</td>
<td>79(75.2)</td>
<td>105(28.3)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Knowledge of FP methods (number of FP methods mentioned)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1-3</td>
<td>42(25.6)</td>
<td>122(74.4)</td>
<td>164(45.9)</td>
<td>9.866</td>
<td>0.020</td>
</tr>
<tr>
<td>&gt;3</td>
<td>58(30.1)</td>
<td>135(69.9)</td>
<td>193(54.1)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

8.6 Health Facility factors

During the survey we found out that most contraceptive methods were available at the health facilities as per policy recommendations of the various levels of care; with the exception of the emergency contraceptives and female condoms (Table 5). However, on
observation health workers would wait for the mothers to demand for FP services before offering such services in the child health clinics.

Table 5: Availability of Family Planning methods in health facilities

<table>
<thead>
<tr>
<th>Available contraceptives</th>
<th>HC II</th>
<th>HC III</th>
<th>HC IV</th>
<th>Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Injectable</td>
<td>√</td>
<td>√</td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td>Pills (Oral contraceptives)</td>
<td>√</td>
<td>√</td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td>IUD</td>
<td>X</td>
<td>√</td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td>Male condoms</td>
<td>√</td>
<td>√</td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td>Implants</td>
<td>X</td>
<td>√</td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td>Female condoms</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Female sterilization</td>
<td>X</td>
<td>X</td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td>Male sterilization</td>
<td>X</td>
<td>X</td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td>Emergency contraceptives</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

During the discussion with midwives and district health officials we found out that some of the challenges at health facility which would hinder effective FP service provision included: Lack of competences and skills of the health workers in FP service provision, Poor attitudes towards FP service provision, and understaffing coupled with excessive work load resulted in lack of integration of FP. The following quotes depict some of the health service related barriers to FP provision:

“..Some health workers do not have competencies, they need to build skills; others have poor attitudes towards FP. Then lack of equipment especially for long term methods, for example if you want to insert an IUD. This can result even in de-motivation of providers”

DNO.
“...but also challenges of accessibility, some parishes have no health facilities, mothers move long distances to access FP services particularly the long term methods. Even at the facility there may be only one midwife who will hence prioritize clinical services. The understaffing results in allocation of days for particular services. A mother comes after walking over 5 km and you tell her to come back tomorrow for FP services, she will definitely not come back” DHO

Lack of adequate knowledge and skills was also highlighted by the service providers themselves.

“...Most of us are still using the information we got in school, for example a man asked me whether he would continue reaching orgasm/having libido even after sterilization (vasectomy) and I did not know what to tell him since I was not sure of the correct information” midwife at HC III.

Other service related barriers pointed out included challenges with the push system of medicines and supplies resulting in not receiving particular contraceptive methods; and limited availability of doctors for permanent methods including vasectomy and bilateral tubal ligation.

The client related factors that hinder mothers from demanding for FP services were the perceived side effects/myths such as low libido, cancers, and abnormalities of the subsequent pregnancies.

‘.Mothers fear to use FP services because they think they will develop cancers from accumulation of the modern contraceptives in their bodies, others complain of excessive or prolonged vaginal bleeding. One mother mentioned that for me my husband has to force me into sex as if I am an animal’ KI Health worker HC II

Potential solutions to the above challenges which were suggested included: Constant supply of contraceptives, periodic orientation of staff, support supervision, and
strengthening referral system for long term methods. In addition the district health officials mentioned partnering with private providers like PACE and Marie Stopes in re-training of providers, offering outreach services and motivation of health workers for better FP services

‘...we need to train health providers and conduct support supervision, and increase their numbers, but this may be difficult, however, we can partner with PACE for training of health providers and Marie Stopes Uganda to carry out outreaches in health facilities. Marie Stopes also motivates those health workers they work with, which would improve performance’

‘.also health workers can regularly carry out community out reaches, and reach mothers in their villages; this would address the physical inaccessibility’ DNO Iganga

8.7 Household/community factors

In this study, failure to discuss family planning issues with the spouse (husband) hindered the chances of FP uptake of a mother, OR = 0.41 (p value=0.000) (Table 6). However, the desirable family size did not affect the likelihood of FP uptake; 28.4% of those who desired 1-4 children used FP compared to 24.5% of those who preferred more than 4 children (p value=0.40). Likewise, previous use of FP did not affect the chances of current FP uptake (p value=0.20).
Table 6: Household/Community factors

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>FP uptake n/%</th>
<th>Non FP uptake n/%</th>
<th>Total n/%</th>
<th>OR/</th>
<th>Pvalue</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discussion of FP with spouse</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>28(17.5)</td>
<td>132(82.5)</td>
<td>160(43.1)</td>
<td>0.409</td>
<td>0.000</td>
</tr>
<tr>
<td>Yes</td>
<td>72(34.1)</td>
<td>139(65.9)</td>
<td>211(56.9)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family size desire (number of children desired)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1-4</td>
<td>66(28.4)</td>
<td>166(71.6)</td>
<td>232(62.5)</td>
<td>0.702</td>
<td>0.402</td>
</tr>
<tr>
<td>&gt;4</td>
<td>34(24.5)</td>
<td>105(75.5)</td>
<td>139(37.5)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Utilization of FP before the current child</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>51(30.2)</td>
<td>118(69.8)</td>
<td>169(83.7)</td>
<td>1.638</td>
<td>0.201</td>
</tr>
<tr>
<td>No</td>
<td>49(24.3)</td>
<td>153(75.7)</td>
<td>202(16.3)</td>
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</tbody>
</table>

During the interviews with men, we found out that men are knowledgeable of the various FP methods and the benefits in using FP. The men also agreed with the fact that even men should take up FP services although they tended to prefer the supportive role to their wives.

“...if I am the head of the household responsible for all family financial burdens, how can I refuse to support my wife to use FP services! The challenge is when a man has more than one wife; the women then start competing in having more children”, KI man Iganga District.
9.0 Discussion

This study assessed the client and health facility factors that contribute to missed opportunities for modern family planning services among women attending child health clinics in Iganga/Mayuge DSS. The findings showed that contraceptive prevalence rate of all methods of 27% is below the national prevalence of 30% (UDHS 2011). This may be because we only interviewed mothers of up to one year after delivery, or due to ineffective service delivery compounded by the low demand from clients. Postnatal care represents a window of opportunity for information; education and communication to newly delivered mothers so that they will make appropriate choices especially towards the care of their infants and themselves, and particularly take decisions on the use of FP methods. However, this opportunity is often missed.

This study revealed that the rate of counseling during child health clinics and immediately after delivery was low at only 24.5% and 23.2% (n=371) respectively. Yet these forms of information exposure were more effective in improving the probability of a mother utilizing FP methods; OR= 2.07 (CI: 1.25-3.43; p=0.005) and OR = 2.32 (CI: 1.39- 3.87, p=0.001, respectively. On the other hand, counseling for FP during ANC clinics is far higher at 65.2% than 18% reported by the study conducted in Kumi (Mbonye 2003), however, this form of passing information regarding FP does not improve chances of a mother to take up FP methods after delivery (p=0.85). This may be because during pregnancy FP may not be viewed as a priority at that time. Mothers may be more concerned with the health of their babies they are carrying and how to go through pregnancy and child birth uneventfully. Family planning uptake becomes of importance after delivery.

Also important to note is that although most mothers (71.7%) were exposed to FP information posters, these did not increase the likelihood of the mothers taking up FP methods (p=0.55). This may be due to the inadequate information (carried on the posters) to address clients’ FP needs. For instance the main barrier to FP uptake mentioned by mothers was baby being still young and mother not having resumed the menstruation yet.
This further highlights the need for mothers to be counseled so that they understand that one can become pregnant even before menstruation resumes after delivery and therefore requires starting on FP methods as soon as possible.

Other health service factors found to hinder provision of quality and effective FP services included limited knowledge and skills of providers. All midwives who were interviewed had not received any form of re-training in FP services updates. Health workers complained of using the pre-service training information which could be outdated or inadequate to address clients’ FP service needs. The findings are similar to those by Kasadde where poor information provision due to limited counseling about modern FP methods was noted (Kasedde 2000). Contrary to what was reported by Mbonye, (2003), poor accessibility to services and inadequate family planning supplies at the facilities did not feature as plausible barriers to FP uptake. This was because all the health facilities visited had contraceptives as per level of care.

Despite the availability of contraceptives in the facilities the demand for them was quite low. Among the client related factors, socio-demographic and economic factors of the respondents including family size desires were not found to influence FP uptake in this study. This is contrary to what is reported by UDHS, 2006. This could be explained by the fact that the population in Iganga/Mayuge DSS has thin socioeconomic demarcations. However, failure of a mother to discuss family planning issues with the spouse was found to reduce the likelihood of a mother utilizing FP services by about 60% (OR=0.41, p=0.00). Similar findings were noted by the study conducted among HIV positive women in Northern Uganda (Nattabi B 2011), and in Asia (Karra MV 1997). This could be explained by the positive attitudes of men towards FP services. This study revealed that men are knowledgeable, appreciate the benefits of FP and are ready to support their spouses. Despite that, 43% of women did not discuss FP issues with their husbands. This may be due to not being typical for couples to discuss FP issues in most developing countries (Bawah AA 1999). Male involvement in reproductive health is therefore crucial to address the communication barriers among couples and improve service utilization.
On the other hand, knowledge of contraceptives improved the chances of FP utilization; the study revealed that knowledge of three or more FP methods was associated with more likelihood of FP uptake (OR 3.76 p=0.02). The findings are similar to those of a study conducted in Kenya slums (Okech 2011). However, despite high knowledge, (at least one method of FP at 96.2%, similar to that noted in UDHS, 2006) uptake of FP services was only about a third (27%). This could be because the mothers have a lot of unexplained questions especially to do with perceived side effects of the contraceptive methods. Fear of side effects was second and mentioned by 23.6% of the respondents as a barrier to FP service utilization. Many mothers believe that modern contraceptives accumulate in the body and cause abnormal vaginal bleeding, cancers and abnormalities with subsequent pregnancies. Others complained of low libido resulting in broken marriages. Unfortunately the low rate of counseling, coupled with inadequate knowledge and skills of health workers to address clients’ fears and misperceptions, and failure of couples to discuss FP issues result in missed opportunities for FP uptake for mothers during the postnatal period.
10.1 Conclusion
This study has highlighted the several missed opportunities and the contributing factors that hinder FP uptake. Counseling of mothers on FP services immediately after delivery/before discharge from a health facility and during child health clinics were found to improve chances of mothers utilizing FP services but unfortunately rarely done. The associated factors included health workers’ limited knowledge and skills in quality FP service provision despite good availability of most of contraceptive methods and supplies. Although many mothers received counseling in ANC clinics and were also exposed to information posters, such exposure is unlikely to influence the uptake of FP services.

Almost all mothers knew at least one method of FP services but this did not impact on FP uptake. However, knowledge of more than three or more methods improved the chances of a mother utilizing FP services. In addition, mothers who did not discuss FP issues with their spouses were more unlikely to utilize FP services. Failure to utilize FP was also due to fear of side effects and the perception that one does not use FP before menstruation resumes. Consequently, the contraceptive prevalence rate among the mothers attending child health clinics was very low yet many mothers wished to use FP in the future.

10.2 Recommendations
1. Integration of FP services in sexual and reproductive health, most especially in child health clinics and immediately after delivery before mothers are discharged is critical in order to improve FP uptake. The MOH should provide a policy framework on provision of postpartum FP services to guide health workers in quality service provision

2. To ensure increased FP uptake strategies should be put in place that promote improved awareness about the available FP services, their possible side effects and benefits among the general population, but especially for women in the reproductive age group.
3. Re-orientation of health providers in FP services is paramount to improve their knowledge and skills as well as motivation for quality and effective service provision, especially given the fact that health facilities and private clinics serve most of the clients’ FP needs/methods.

4. Male involvement in reproductive health services is crucial; thus strategies geared towards mobilization of men to participate and communicate with their spouses regarding FP issues should be considered by programme planners.
References


DSS (2010). "Iganga/Mayuge Demographic Surveillance Annual report."


HMIS (2010). "Health Management Information System ".


UDHS (2011). "Uganda Demographic Health Survey."


Annex 1. Questionnaire for mothers

Questionnaire for Missed opportunities for modern Family Planning services

Start time; _____:_____

Interview Date_/__/__

Interviewer Name

RESPONDENT’S IDENTIFICATION PARTICULARS

DISTRICT

_________________________________________

COUNTY

_________________________________________

SUBCOUNTY/TOWN

_________________________________________

PARISH/LC2 NAME

_________________________________________

VILLAGE/LC1 NAME

_________________________________________

NAME OF HEALTH FACILITY

_________________________________________

LEVEL OF FACILITY

1) Hospital
2) HC IV
3) HC III
4) HC II

A. SOCIAL DEMOGRAPHIC

1. Nyabo, amaina go niwe ani? Mother’s Name

2. How old are you? (completed years) 

3. Wazalibwa mwaka ki ate omwezi ki? In what year and month were you born? Year

37
Don’t know year. ................. 96

Month . ................

Don’t know month. ...............96

4. Olimufumbo? *What is your marital status?*

Married . ............. 1

Divorced/Separated. ....... 2

Widowed ............. 3  SKIP TO 6

Single .............. 4  SKIP TO 6


1 = Yes    2= No    96= Do not know

6. Omwana wa myezi emeka? *Age of Baby in Months*   .................

7. Wakafunaku amabundha emirundi emeka? *Number of pregnancies mother has had*

          .........................

8. Wakazala abaana bameka? *Number of children mother has had*   .................

9. Bameka abakali abalamu? *Number of children who are alive*   .........................

10. Oli wandhikiriza ki? *What is your religion?*

Catholic ............. 1

Protestant ........... 2

Muslim ............... 3

Pentecostal ........... 4

SDA .................. 5

Others ............... 6
11. Wasomaku? *Have you ever attended school?*
   
   **Yes= 1**   **No = 2 IF NO SKIP TO Q13**

12. Wakoma mukyakumeka? *What is the highest level of school you attended: primary, 'O' level, 'A' level, or university or tertiary?*
   - Primary ...................... 1
   - O' level ...................... 2
   - A' level ...................... 3
   - Tertiary ...................... 4
   - Vocational ...................... 5
   - University ...................... 6

13. Mulimoki ogwenkalakalira gwokola? *What is your primary (main) occupation?*
   - Salaried worker ...................... 1
   - Business .................................
     - Laborer ................................. 2
     - Peasant farmer ...................... 3
     - House wife ............................. 4
   - Others (SPECIFY) ...................... 6

14. Ibawo yasoma ku? *Did your husband attend school? (ASK ONLY THOSE CURRENTLY MARRIED)*
   - Yes= 1   No= 2 (skip to Q15)   Don’t know = 3 (skip to Q16)

15. Balo yakoma mukibina kya kumeka? *What is the highest level of school that your husband attended?*
   - Primary .......................... 1
   - O' level .......................... 2
   - A' level .......................... 3
   - Tertiary .......................... 4
   - Vocational ........................ 5
   - University ........................ 6

16. Balo akola mulimoki ogwenkalakalila? *What is the primary (main) occupation of your husband?*
   - Salaried worker ............................. 1
Business……………………………………………………… 2
Labourer (Daily wage) ........................... 3
Peasant farmer. ................................. 4
Others (specify)………………………………………………

17. Mu makago, ghaliwo alina ekimu kubino? Does any member of your household own the following?

<table>
<thead>
<tr>
<th>Item</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) BICYCLE</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>b) MOTORCYCLE/SCOOTER</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>c) ANIMAL-DRAWN CART</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>d) CAR/TRUCK</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>e) BOAT WITH MOTOR</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>f) BOAT WITH NO MOTOR</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>g) Radio</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>h) Mobile phone</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

B. ANTENATAL CARE AND DELIVERY (All questions in B refer to care during pregnancy and delivery)

18. Bwe ghali amabundha ghajja bakukeberaku/wanwaku obulezi? During the last pregnancy, did you attend antenatal care? (ANC)

Yes = 1
No = 2 (skip to 21)

19. Milundi emeka jeghaja okukukebera? How many times did you attend ANC?

-------------

20. Kumabundha go’ mwana oyo (agasembayo), bakukoberaku bya Famile planning? During ANC visits, were you counseled on Family planning services?

Yes = 1
No = 2

21. Wazalila gha? Where did you deliver from? (READ TO THE RESPONDENT)

<table>
<thead>
<tr>
<th>Place of delivery</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital</td>
<td>1</td>
</tr>
<tr>
<td>Health centre</td>
<td>2</td>
</tr>
<tr>
<td>Private clinic</td>
<td>3</td>
</tr>
<tr>
<td>TBA</td>
<td>4</td>
</tr>
</tbody>
</table>
22. Bwewamala okuzaala bakukobelaku/ Oyo eyakuzalisa yakukoberaku ebya Famile? Did the attendant at delivery counsel you on Family planning services?  
Yes = 1  
No = 2

23. Ngeri ki abantu gyebayinza okwekumisa obutafuna mabundha? What are the ways or methods a couple can use to delay or avoid a pregnancy? DO NOT PROMPT/PROBE  
a. Female sterilization  
b. Male sterilization  
c. IUD  
d. Injectables  
e. Implants  
f. Pill (oral contraceptives)  
g. Female condom  
h. Male condom  
i. Emergency Contraceptives  
j. Spermicides  
k. Lactational amenorrhea method  
l. Rhythm method  
m. Withdraw  
n. Other; specify…………………………………………………………………………………………………………………………

24. Nani asalawo ku byobudhandhabi mu makago? Who makes decisions regarding health care in your home?  
A. Husband  
B. Myself  
C. Mother In-law  
D. Other

25. Wali oyogeyilemu ni balo ku bya Famile planning? Have you ever discussed with your spouse family planning issues?  
1= Yes  
2= No

26. Wandyenze kuzaala baana bameka? How many children would you like to deliver? __________

27. Ate balo ayenda muzaale baana bameka? How many children does your husband want? _______
28. Mu clinic oyogilemu nabakyala abandi ku bya Famile planning? *Did you discuss family planning issues with other mothers at the clinic?*  
   1 = Yes  
   2 = No

29. Oboineku ebiwandiko/ebifananhi ebigemagana ni Famile planning mu cli n? *Did you see any poster/Education charts on Family planning services displayed in the clinic?*  
   1 = yes  
   2 = No

30. Abasawo bakwinonoyileku ku nkola eya Famile planning? *Have you been counseled on Family planning services at the clinic?*  
   1 = Yes  
   2 = No (SKIP TO 43)  
   If yes in 30 above; which of the following methods have you heard about? WRITE THE ANSWERS IN THE PROVIDED BOX; *(YES=1 NO=2)*

<table>
<thead>
<tr>
<th></th>
<th>Description</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>31.</td>
<td><em>Okusala enseke edha bakyala; Female sterilization</em> (women can have an operation to avoid having any more children)</td>
<td>[ ]</td>
</tr>
<tr>
<td>32.</td>
<td><em>Okusala enseke edha basadha; Male sterilization</em> (men can have an operation to avoid having any more children)</td>
<td>[ ]</td>
</tr>
<tr>
<td>33.</td>
<td><em>Akaweta; IUD</em> (women can have a loop or coil placed inside them by a doctor or a nurse)</td>
<td>[ ]</td>
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<tr>
<td>34.</td>
<td><em>Empiso; injectables</em> (an injection that stops women from becoming pregnant for 1 or more months)</td>
<td>[ ]</td>
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<tr>
<td>35.</td>
<td><em>Kapizo; Implants</em> (women can have one or more small rods placed in their upper arm by a doctor or nurse which can prevent pregnancy for one or more years)</td>
<td>[ ]</td>
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<tr>
<td>36.</td>
<td><em>Obukelenda obwa famile; Pill</em> (Women can take a pill every day to avoid becoming pregnant)</td>
<td>[ ]</td>
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<tr>
<td>37.</td>
<td>Male Condom (Men can put a rubber sheath on their penis before sexual intercourse)</td>
<td>[ ]</td>
</tr>
<tr>
<td>38.</td>
<td>Female Condom</td>
<td>[ ]</td>
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</tbody>
</table>
(Women can place a sheath in their vagina before sexual intercourse)

| 39. | Okwonsya nti kutangila obutafuna ndha Lactational amenorrhea method | □ |

| 40. | Rhythm method (moon beads (obunere) oba enkola ya calenda oba) (a woman can avoid pregnancy by not having sexual intercourse on the days of the month she is most likely to get pregnancy) | □ |

| 41. | Obutamillamu mumukyala Withdrawal (men can be careful and pull out before climax) | □ |

| 42. | Emergency contraception (as an emergency measure, within three days after they have unprotected sexual intercourse, women can take special pills to prevent pregnancy) | □ |

| 43. | Spermicides | □ |

| 44. | Eliyo engeri yona yona jolikozesa okwewala okufuna amabundha? Are you currently doing something or using any method to delay or avoid getting pregnant? 1=yes 2= No (skip to 48) | □ |

| 45. | Olikoseza engeri kyi ? Which method are you currently using? (PROBE for each method, select all mentioned) | □ |

<p>| a | Female sterilization | □ |
| b | Male sterilization | □ |
| c | IUD | □ |
| d | Injectables | □ |
| e | Implants | □ |
| f | Pill | □ |
| g | Condom | □ |
| h | Female condom | □ |</p>
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<tr>
<td>Diaphragm</td>
<td>Foam/Jelly</td>
<td>Lactational Amen. Method</td>
<td>Rhythm method</td>
<td>Withdrawal</td>
<td>Other method</td>
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**IF YES IN ANY OF THE ABOVE, THEN SKIP TO 112**

<p>| | | | | | | | |</p>
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</table>
| 46. | Engeli ya Famile planning gyolikoza wa gitolawa? Source of the Family planning method?
|   | a. Health facility |
|   | b. Private clinic |
|   | c. Drug shop |
|   | d. General shop |
|   | e. Other (specify) .............................................................. |

| 47. | Ng’omaze okuzaala, enkola ya Famile planning wagitandika li? When did you start using family planning method after delivery? .......... (months) |

<p>| 48. | If No above in 44; Why? (Circle appropriately) |
|   | a. Would like to get pregnant |
|   | b. I am currently pregnant |
|   | c. My spouse/husband refused me |
|   | d. My husband has another woman producing any way |
|   | e. Social security |
|   | f. I have to deliver all children God gives me |
|   | g. Side effects of contraceptives |
|   | h. Costly |
|   | i. I do not know where to access the Family planning services |
|   | j. Family planning services are lacking at the nearby health unit |</p>
<table>
<thead>
<tr>
<th></th>
<th>Lactation amenorrhea</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>l.</td>
<td>Other explain</td>
<td></td>
</tr>
</tbody>
</table>

| 49. | Do you wish to use a method to delay or avoid getting pregnant in the future? *Osubila okukozesaku engeri yona yona okwewala okufuna amabundha jebwidha.* 1 = yes 2 = No |
| 50. | Nga’okali kuzaala omwana onno wakozesaku Famile? Before pregnancy for this baby had you ever used any family planning method? 1 = Yes 2 = No |

End Time......../............  THANK YOU FOR YOUR PARTICIPATION
Annex 2: Key informant Interview guide for district health team (DHT)

I am ........................................ from MakSPH-CDC Fellowship programme. We are conducting a health facility based study to establish the factors that contribute to missed opportunities for Family Planning (FP) services in the facilities in Iganga DSS so as to inform policy and development partners. Due to your experience and position you have been chosen to participate in the study.

Please feel free to discuss/participate and ask for clarification where necessary. All the information you provide will be handled in a strictly confidential manner and nothing you will say will make us unhappy. You do not have to reveal information that makes you uncomfortable if you do not want to, but if you are willing to share your experiences; it will be very helpful to us in understanding issues relating to FP service provision within the facilities.

I also have a tape recorder that will help me to capture the discussion/interview to ensure that I do not miss anything. Do you mind if i use the tape recorder? [Interviewer seeks and documents consent of the respondent.

Thank you very much

Questions

1) How should family planning services be provided at health facilities and by whom?
2) How should such health providers be trained and by whom, and how often?
3) How should these health workers be supervised and by whom? How are they currently supervised?
4) How should these health workers be motivated to enable them provide quality services? How are they being motivated?
5) What are the barriers to FP service provision? Why do you think some mothers do not receive FP services when they bring their infants for care/immunization at the health facilities?
6) What challenges are the health providers likely to face in provision of FP services? How can they be overcome?
7) What else needs to be done to ensure quality FP service provision so as to avoid missed opportunities?
8) Do you have anything else you would like to add?

Thank you very much for your time
Annex 3: Interview tool for health workers on Family planning service provision

SECTION 1: FACILITY IDENTIFIERS

<table>
<thead>
<tr>
<th>Variable</th>
<th>Variable code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date</td>
<td>__</td>
</tr>
<tr>
<td>District</td>
<td>______________</td>
</tr>
<tr>
<td>Facility name</td>
<td>______________</td>
</tr>
<tr>
<td>Sub-county name</td>
<td>______________</td>
</tr>
<tr>
<td>Facility Type</td>
<td>__</td>
</tr>
<tr>
<td>1HC2 (2)HC3 (3)HC4 (4)Hosp</td>
<td>__</td>
</tr>
<tr>
<td>Facility Ownership</td>
<td>__</td>
</tr>
<tr>
<td>1Govt (2)Mission (3)NGO (4)CBO</td>
<td>__</td>
</tr>
<tr>
<td>Interviewer Initials</td>
<td>__</td>
</tr>
<tr>
<td>How many health providers are in the reproductive department of this health unit?</td>
<td>______________</td>
</tr>
<tr>
<td>How many health providers have been trained in family planning services in the last three 3 years?</td>
<td>______________</td>
</tr>
</tbody>
</table>

Current availability of family planning supplies (Observe where appropriate)
Which of the following family planning supplies are available in this clinic today?  
1) Yes  
2) No  

<table>
<thead>
<tr>
<th></th>
<th>Variable Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td>Condoms</td>
</tr>
<tr>
<td>11</td>
<td>Oral hormonal contraception</td>
</tr>
<tr>
<td>12</td>
<td>Injectable hormonal contraception/implants</td>
</tr>
<tr>
<td>13</td>
<td>Implants</td>
</tr>
<tr>
<td>14</td>
<td>IUD</td>
</tr>
<tr>
<td>15</td>
<td>Do you conduct female sterilization from this unit</td>
</tr>
<tr>
<td>16</td>
<td>Do you conduct male sterilization in this unit</td>
</tr>
</tbody>
</table>

Current availability of health education materials and protocols

*Ask to see each item for yourself*

<table>
<thead>
<tr>
<th></th>
<th>Variable Code</th>
</tr>
</thead>
</table>
| 17 | Protocol for use for IUD insertion available in the clinic today  
(1) Yes  
(2) No |
| 18 | Posters/leaflets promoting family planning/ birth spacing displayed in the clinic today |

19. What are the services provided in the child health clinics?  
20. Are family planning services routinely provided to all mothers in the child health clinics?  
   If no, why do some mothers not receive Family planning services?  
21. What are the challenges you face in family planning service provision?  
22. How can those challenges be over come in order to improve family planning service provision?
Annex 4: Key informant Interview guide for men

I am ........................................ from MakSPH-CDC Fellowship programme. We are conducting a health facility based study to establish the factors that contribute to missed opportunities for Family Planning (FP) services in the facilities in Iganga DSS so as to inform policy and development partners. Due to your experience and position you have been chosen to participate in the study.

Please feel free to discuss/participate and ask for clarification where necessary. All the information you provide will be handled in a strictly confidential manner and nothing you will say will make us unhappy. You do not have to reveal information that makes you uncomfortable if you do not want to, but if you are willing to share your experiences; it will be very helpful to us in understanding issues relating to FP uptake within the facilities.

I also have a tape recorder that will help me to capture the discussion/interview to ensure that I do not miss anything. Do you mind if i use the tape recorder? [Interviewer seeks and documents consent of the respondent.

Thank you very much

Questions

1. What do you understand by FP?
2. What are the various methods of FP you know?
3. What are the methods for men?
4. Do you think men should also use FP methods? If yes, why? And if no, why?
5. What are the challenges men encounter in using FP?
6. What are the benefits of FP to the family and community?
7. What are the challenges/barriers women find when trying to access and use FP services
8. What are the challenges at the health facilities that women and men face when trying to access care and specifically FP services
9. How can such challenges/barriers be overcome?
10. How can men support their wives in using FP?
11. How else can women and men be supported to use FP services?
12. Is there any other suggestion on how to improve uptake of FP services in order to avoid missed opportunities?

Thank you for your time
Annex 5: Informed consent form for mothers

Introduction and Purpose of the research:

I am ________________________, and I work with the School of Public Health, Makerere University. We are conducting a health facility based survey in order to understand family planning service delivery.

In order to improve uptake of modern family planning services the district and stakeholders require current information on barriers to uptake of modern family planning services in child health clinics so as to design appropriate interventions.

Procedure

We/I therefore, invite you to take part in this survey. If you accept, you will be required to answer questions which will be administered by [………………………………………name of research assistant].

To find answers to some of the questions, we invite you to take part in this study. If you accept, you will be required to answer questions concerning the care you have just received. This information is very important to us and will inform design of interventions to improve delivery of family planning services for mothers in health facilities in this district and other places in Uganda. You can choose to accept or not to accept to participate in the interview.

This interview will take about 20 minutes to complete. However, you can ask me to stop at any time.

If you do not wish to answer any of the questions included in the survey, you may skip them and we move on to the next question. The information recorded is considered confidential, and no one else except the research team will have access to the survey.

Risks and Discomforts:

You may refuse to answer any question or not take part in a portion of the survey if you feel the question(s) make you uncomfortable.

Benefits:

There will be no direct benefit to you, but your participation will help the district and stakeholders design appropriate interventions to improve uptake of the family planning services in order to improve maternal and child welfare in the district and the country at large.

Incentives:
You will not be paid money or in kind for participating in the research.

Confidentiality:

The information that we collect from this study will be kept confidential. Information about you that will be collected from the study will be stored in a file that will not have your name on it, but a number assigned to it instead. The name associated with the number assigned to each file will be kept under lock and key and will not be divulged to anyone except the research team and the sponsors.

Right to refuse or withdraw:

You do not have to take part in this research if you do not wish to do so, and you may stop participating in the interview at any time that you wish.

Who to contact:

If you have any questions you may ask those now or later. If you wish to ask questions later, you may contact the following:

Dr Gertrude Namazzi, Makerere University School of Public Health-CDC Fellowship, Tel: 256-772-458835, e-mail: namazzi_ge@yahoo.co.uk

Certificate of Consent for the Survey

I have been invited to take part in the research on missed opportunities for modern family planning services among women attending child health clinics.

I have read the foregoing information, [or it has been read to me]. I understand that the purpose of this research study is to establish barriers to uptake of modern family planning services in child health clinics. This will be by interview and the time involved is about 20 minutes. I am free not to answer. There are no direct benefits to me from this research but the findings will help the district/stakeholders in designing appropriate interventions

I have had the opportunity to ask questions about it and any questions I had have been answered to my satisfaction. I consent voluntarily to be a participant in this study and understand that I have the right to withdraw from the interview at any time without in any way affecting my rights.
There may be some discomforts on questions that I may not feel comfortable with, however, I am free not to answer.

The information that I will give is going to be kept confidential. Nobody except the research team will have access to it. The names will not be recorded. Numbers will replace the names. I consent voluntarily to be a participant in this study and understand that I have the right to withdraw from the interview at any time without in any way affecting my rights.

Name of Participant                                      Date and Signature of Participant
                                                        
                                                        ___/___/___ (dd/mm/yy)

Name of Researcher/Moderator                          Date and Signature of
Researcher/Moderator                                     
                                                        
                                                        ___/___/___ (dd/mm/yy)
Annex 6: Informed consent form for health workers

Introduction and Purpose of the research:

I am ______________________, and I work with the School of Public Health, Makerere University. We are conducting a health facility based survey in order to understand family planning service delivery.

In order to improve uptake of modern family planning services the district and stakeholders require current information on barriers to uptake of modern family planning services in child health clinics so as to design appropriate interventions

Procedure

We/I therefore, invite you to take part in this survey. If you accept, you will be required to answer questions which will be administered by [………………………………………name of research assistant].

You are being invited to take part in this interview because we feel that your experience in this health facility in the district can contribute much to this research.

If you do not wish to answer any of the questions included in the survey, you may skip them and we move on to the next question. The information recorded is considered confidential, and no one else except the research team will have access to the survey.

The expected duration of the interview is about 20 minutes.

Risks and Discomforts:

You may refuse to answer any question or not take part in a portion of the survey if you feel the question(s) make you uncomfortable.

Benefits:

There will be no direct benefit to you, but your participation will help the district and stakeholders design appropriate interventions to improve uptake of the family planning services in order to improve maternal and child welfare in the district and the country at large.

Incentives:

You will not be paid money or in kind for participating in the research.

Confidentiality:
The information that we collect from this study will be kept confidential. Information about you that will be collected from the study will be stored in a file that will not have your name on it, but a number assigned to it instead. The name associated with the number assigned to each file will be kept under lock and key and will not be divulged to anyone except the research team and the sponsors.

Right to refuse or withdraw:

You do not have to take part in this research if you do not wish to do so, and you may stop participating in the interview at any time that you wish.

Who to contact:

If you have any questions you may ask those now or later. If you wish to ask questions later, you may contact the following:

Dr Gertrude Namazzi, Makerere University School of Public Health-CDC Fellowship, Tel: 256-772-458835, e-mail: namazzi_ge@yahoo.co.uk

Certificate of Consent for the Survey

I have been invited to take part in the research on missed opportunities for modern family planning services among women attending child health clinics.

I have read the foregoing information, [or it has been read to me]. I understand that the purpose of this research study is to establish barriers to uptake of modern family planning services in child health clinics. This will be by interview and the time involved is about 20 minutes. I am free not to answer. There are no direct benefits to me from this research but the findings will help the district/stakeholders in designing appropriate interventions

I have had the opportunity to ask questions about it and any questions I had have been answered to my satisfaction. I consent voluntarily to be a participant in this study and understand that I have the right to withdraw from the interview at any time without in any way affecting my rights.

There may be some discomforts on questions that I may not feel comfortable with, however, I am free not to answer.

The information that I will give is going to be kept confidential. Nobody except the research team will have access to it. The names will not be recorded. Numbers will replace the names. I
consent voluntarily to be a participant in this study and understand that I have the right to withdraw from the interview at any time without in any way affecting my rights.

Name of Subject                                      Date and Signature of Subject
________________________________________          __________________________________________

__/__/____ (dd/mm/yy)

Name of Researcher/Moderator                          Date and Signature of Researcher/Moderator
________________________________________

__/__/____ (dd/mm/yy)